CLOSING THE GAPS IN THE NATION'S HEALTH SERVICES FOR MOTHERS AND CHILDREN*

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Of the many significant conferences sponsored by The New York Academy of Medicine, the *Conference on Perinatal Mortality*, held October 29, 1957, is one that is outstanding. The conference served to bring out the increasing disparity in our large cities between the rapidly growing population dependent on public and voluntary medical resources for their care and our ability to respond to the increasing needs. The events since 1957 have confirmed what was foreseen in the conference and we are now beginning to take steps that, we hope, will contribute to the solution of some of the problems.

In her remarks concluding the conference, Dr. Leona Baumgartner said with reference to the question of the necessary funds to do what needs to be done, "I'm really not worried about this aspect of the problem. In our country, if people have good ideas . . . the money can always be found to do the job. We need to decide what we should do and how we are going to do it. That, I think, is the challenge this conference has left us." This year, we are witnessing the most significant health legislation since the Social Security Act was passed in 1935. H.R. 6675, together with the 1963 Maternal and Child Health and Mental Retardation Planning Amendments to the Social Security Act, are providing us with the opportunity to do what needs to be done to improve the health of mothers and children.

To speak of perinatal mortality is to use indices of public health that were much more useful a generation ago. Yet we must speak of these problems because they are very much with us today and they represent gaps in our services. This country has made substantial achievements in the reduction of these mortality rates and in the pro-

*Presented in a panel discussion, Today's Gaps in Health Care and Barriers to Service, given as part of The 1965 Health Conference of The New York Academy of Medicine, *Closing the Gaps in the Availability and Accessibility of Health Services,* held at the Academy, April 29 and 30, 1965.

motion of the health of our population. Yet while infant mortality declined appreciably between 1950 and 1960, it rose significantly in 7 of our 10 largest cities. Whereas our large cities used to have more favorable rates, we find that 9 of the 10 largest cities in 1960 had infant mortality rates that exceeded the national average. While our national rate of about 25 per 1,000 live births represents considerable progress, when we analyze the rate we see wide variations among the states ranging from 18.6 to 41.3 per 1,000 live births; the rate for nonwhite people is about twice as high as for white.

These data point to a concentration of maternal and child health problems in our large cities as well as in the most rural counties. They reflect the major social changes that have been taking place in our large centers of population. The period since the war has seen major shifts in population with large numbers of people moving from rural areas to industrial cities. The huge increase in the suburban population has resulted chiefly from the movement of middle-class families from the cities as well as from the increase in the total population. The resident population in our large cities is now made up increasingly of low-income families. Thus we see that about one third of Chicago's babies are born in the low-income census tracts; in the city of New York about one third of the infants receive their health supervision at the Health Department's well-baby clinics and, in one district of the city, the proportion is more than 80 per cent; of maternity patients in Dallas, Texas, one third are staff patients who make partial or no payment; in the District of Columbia, only 40 per cent of the births to residents of the city are attended as private patients; this is the case also in Atlanta, Ga., Cleveland, Ohio, Detroit, Mich., and elsewhere.[1]

In this period of great affluence in the United States what kind of medical care is this large number of maternity patients receiving? We know that these patients are greatly straining the resources of their communities. For the most part they receive outpatient and hospital care in tax-supported hospitals, because voluntary hospitals, to an increasing extent, require payment by or in behalf of every patient. The result has been a great overcrowding of many tax-supported hospitals which, together with understaffing, is leading to conditions incompatible with a decent quality of care.

In order for a hospital to accommodate such large numbers of maternity patients, it may be necessary to discharge maternity patients

within 24 to 48 hours after delivery. A basic challenge, then, is so to organize our community resources that we have a more equitable distribution of the low-income patients among the hospitals and clinics in a community. We cannot continue indefinitely the situation that exists in one of our largest cities, for example, in which the tax-supported hospital has 20,000 deliveries a year, and was built for about 5,000, while some voluntary hospitals in the same city have only 60 per cent to 70 per cent occupancy in their obstetric departments. We find similar situations in most of our major cities.

Under such circumstances, it is not surprising that a large proportion of expectant mothers in low-income families are giving birth after having had little or no prenatal care. For example, about half of the women delivered at the city hospital in Washington, D. C., have had no prenatal care; in other cities we find it characteristic of this group that between a third and a half have had little or no prenatal care. These same mothers give birth prematurely to an alarming extent, low birth-weight rates among them being commonly 15 per cent to 20 per cent, or two to three times the expected rate.

It is essential to understand why we have such a large number of patients who have their babies with little or no prenatal care if we are to take the necessary steps to close the gaps in the availability of health services for mothers and children. The results of several studies shed light on the problem.

1) There is a trend toward centralizing care for this group of patients in fewer and fewer facilities. The inconvenience and expense of transportation from the patient's neighborhood to the center may be great enough to discourage a visit. For a pregnant woman with one or more children, transportation can be most troublesome and costly.

2) Unrealistic financial eligibility requirements are a major deterrent to prenatal care. Eligibility requirements vary; many patients are ineligible under too-restrictive financial requirements and yet cannot afford to pay the rate many hospitals charge staff patients. Ineligible patients may have to call an ambulance when in labor and be taken to the nearest hospital.

3) The recent study by the Maternity Center Association, New York, N. Y., vividly illustrates the effects of overcrowding. Overcrowded clinics and long waiting periods cause many patients to feel the visits are not worthwhile.

4) Many expectant mothers in low-income families work and, for them, taking the day off to go to the clinic involves financial loss. Night clinics help to solve this problem.

5) A considerable number of patients have recently moved into the cities from rural areas and do not understand the importance of prenatal care.

The problems of maternity care and the association between prematurity and brain damage led the President's Panel on Mental Retardation to focus on the importance of prenatal care in one of its major recommendations. Shortly afterward, the 1963 Maternal and Child Health and Mental Retardation Planning Amendments, P.L. 88-156, was enacted. This statute authorizes an appropriation administered by the Children's Bureau, which provides funds on a project basis to assist state and local health departments. The Bureau may pay up to 75 per cent of the costs of programs of comprehensive maternity and infant care for women who have conditions associated with pregnancy that increase the hazards of childbearing for themselves and for their infants, and who are unlikely to receive the care they need either because they are from low-income families or for other reasons beyond their control.

These medical-care programs make it possible to: 1) increase the number of prenatal and postnatal clinics; 2) bring the prenatal and postpartum clinics close to the population served; 3) establish special clinics for those patients with complications of pregnancy, so that more time can be given them by obstetricians, nurses, social workers, nutritionists, and others; 4) pay for hospital care not only for the delivery but also during the prenatal period as needed; 5) relieve overcrowding in tax-supported hospitals by paying for care in voluntary hospitals; 6) pay for hospital care of premature infants and other infants needing special attention.

The appropriation for the maternity- and infant-care projects is $15 million for 1965; $30 million is authorized for 1966. One year has passed since the appropriation first became available, and in that period 16 projects have been approved. There are many interesting features in these programs although only a few can be mentioned here. Almost all offer family planning as part of maternity care. Several employ nurse-midwives to provide some of the maternity care. The Children's Bureau is supporting the training of nurse-midwives in several uni-

versities. This is one way, as yet not widely acceptable, of meeting the problem of the insufficient number of physicians for maternity care.

New Programs for Children

The problems outlined above that low-income families experience in obtaining adequate medical care are not limited to obstetrics. Such families have similar difficulties in obtaining care for their children. This is brought out in a report prepared by the Children's Bureau in response to a request made to the Secretary of the Department of Health, Education, and Welfare by President John F. Kennedy in his special Youth Message to the Congress on February 14, 1963. Secretary Anthony J. Celebrezze's transmittal letter to the President states:[2]

> The material in the enclosed report on Health of Children of School Age emphasizes the gaps in child health supervision in the preschool years with the resultant wide disparity in the readiness of children to begin their education; the great crowding of well-baby clinics and hospital outpatient departments in the cities; the inadequacies in the quantity and quality of medical care received by children in many low-income families; the need for more effective methods of casefinding in the presence of a shortage of physicians; the special problems of adolescents and the handicapped—all pointing to the need for new approaches and for concentrating our community resources where they are most needed.

The report reveals that children have a large burden of illness and many of these conditions interfere with their growth, development, and education. While acute and chronic illnesses strike all children, the need for help in obtaining medical care is greatest among the poor. About one third of our children live in low-income families, which tend to be concentrated in large cities or in depressed rural counties.

That clinics for these children are crowded is illustrated by the following examples. In Washington, D. C., the health department reported on February 18, 1963, that 1,190 school children were on the waiting list for eye examinations at the clinic. In Brooklyn, N. Y., the city health department has opened a Pediatric Emergency and Treatment Clinic in one of its health centers because of the great crowding of the hospital outpatient departments. About 1,000 children are seen in the clinic each month.

The great increase in the role of the emergency room in providing medical care is a startling development. Dr. Bertram Brown has written regarding the emergency room at the Grace-New Haven Community Hospital in New Haven, Conn.:[3]

> . . . For the pediatric emergency room group, almost half have chosen the hospital as their "family physician." Yet the emergency room is clearly set up at present to give care to isolated cases and acute situations. The majority of cases seen in our study needed care of a more comprehensive, continuous nature. It seems clear that our medical leaders and hospital administrators must make plans to give appropriate medical care in accordance with new and changing community needs.

Dr. Brown further found that of the patients seen at this hospital's emergency room:

1) 43 per cent of the families used this facility as their only source of medical care.
2) 47 per cent of the emergency room patients were Negro, although Negroes represent only 5.8 per cent of the New Haven population. (This was believed due to definite barriers the Negro population were experiencing in obtaining private medical care.)
3) 59 per cent of the patients were under 3 years of age.
4) Only 20 per cent were considered seriously ill or "medical emergencies."
5) The patients seen in the daytime were as ill as those seen between midnight and 8 a.m.
6) 91.5 per cent of the patients were sent home and only 8.5 per cent were admitted to the hospital.

In recognition of the "great and growing needs among our children for better health services," President Lyndon B. Johnson gave children a high priority in his Health Message to the Congress of January 7, 1965. Included in Title II of H.R. 6675, the noncontroversial title of the bill, are significant provisions for extension of maternal and child-health and crippled-children's services, and for a new authorization for special project grants for the health of school and preschool children. Such grants could be made to state or local health departments, state crippled-children's agencies, and to medical schools and teaching hospitals affiliated with such schools to pay up to 75 per cent of the costs

of projects of a comprehensive nature for health services and medical care for children and youth of low-income families. Projects for children and youth of school age must include screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, both medical and dental. There is authorized $15 million for the year beginning July 1, 1965, increasing by steps to $50 million for the fiscal year 1970.

Here, again, the project-grant method is used to support a medical-care program, thereby making it possible to concentrate financial resources in geographic areas where the need is greatest. In carrying out such a program the responsible community agency must show that the services provided will be coordinated with other state or local health, education, and welfare programs.

We feel that this legislation, together with the 1963 maternity-care amendments, will make it possible for communities to develop high-quality, comprehensive, and well-organized programs of preventive health services and medical care for mothers and children. It will mean that the best medical resources in our communities will have a new reason to plan together to meet the problems of providing good medical care for mothers and children. It will offer an unprecedented opportunity for medical schools and teaching hospitals to practice and teach medicine with a greater understanding of the patient's life outside of the hospital. It will facilitate a better distribution of patients among the available resources of the community and halt the growing trend toward hospital ghettoes.

With the wholehearted support of the federal administration in providing the health professions with this opportunity of improving the health of mothers and children, it is clear to me that if we have the imagination, the ideas, and the motivation, there is no doubt that we can accomplish our objectives.

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